

In contrast, respondent agrees with the Assistant Director's Preliminary Decision and requests the Appeals Board (Board) to affirm the decision. Respondent contends that claimant failed to prove her left upper extremity complaints were related to her work for respondent. Furthermore, respondent argues claimant's medical treatment records indicate claimant was released to return to work on October 14, 2002, and she is, therefore, not temporarily and totally disabled.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the preliminary hearing record and considering the parties' briefs, the Board makes the following findings and conclusions:

Claimant worked as an assistant manager in one of respondent's grocery stores until she resigned from that employment on August 17, 2001, because of safety issues. Initially, claimant made a claim for work-related injuries to her right upper extremity resulting from repetitive work activities she performed from January 1, 2001, until her last day worked of August 17, 2001.

Respondent first provided claimant with medical treatment through Robert E. Jevons, M.D. Dr. Jevons' earliest medical note is dated July 17, 2001, and indicates, "No lifting over 10 # for 6 weeks."¹ Dr. Jevons then continued claimant off work in a medical note dated September 11, 2001, for right lateral epicondylitis and placed claimant in a physical therapy program.² Eventually Dr. Jevons referred claimant for consultation with Prem Parmar, M.D., of Orthopaedic Professional Association.

Dr. Parmar first saw claimant on November 8, 2001, with complaints of right elbow pain for 5 months. He provided claimant with conservative medical treatment which included anti-inflammatory medication, cortisone injections, and physical therapy. Because claimant did not improve with the conservative medical treatment, on December 21, 2001, Dr. Parmar performed a right tennis elbow release. While claimant was recovering from the elbow surgery, claimant underwent EMG and nerve conduction testing that found early right median nerve compression neuropathy or carpal tunnel syndrome.

On June 28, 2002, claimant underwent a right carpal tunnel release performed by Dr. Parmar. In July 2002, while recovering from the carpal tunnel release surgery, claimant started having numbness in her left hand. Claimant first notified Dr. Parmar of her left hand numbness during an August 5, 2002, post-right carpal tunnel release followup visit. But Dr. Parmar's August 5, 2002, medical note does not indicate that claimant made any left hand complaints.

Claimant testified, however, that she did make those complaints to Dr. Parmar and he simply indicated to claimant that her left hand was just jealous because it had not been getting as much attention as her right hand.

Dr. Parmar next saw claimant on September 30, 2002. In that medical record, he noted that claimant was now complaining of "what sounds like to be left carpal tunnel

¹ P.H. Trans., Resp. Ex. A.

² P.H. Trans., Resp. Ex. A.

syndrome, which is I think is a new thing.”³ Dr. Parmar then referred claimant to Dr. S. R. Katta, M.D., another physician in Dr. Parmar’s same medical group, for claimant’s continuing right upper extremity symptoms and her new left upper extremity symptoms.

Dr. Katta saw claimant on October 8, 2002. He placed claimant in a physical therapy program to ease her right elbow tendinitis pain. From Dr. Katta’s clinical examination of claimant, he diagnosed claimant with left carpal tunnel syndrome. He advised claimant to obtain a left wrist support splint for the carpal tunnel syndrome condition. He also recommended claimant undergo nerve conduction studies to confirm the left carpal tunnel syndrome diagnosis.

Next, claimant was seen by Dr. Parmar on October 14, 2002. Before that appointment, claimant had undergone a FCE, as ordered by Dr. Parmar, on October 4, 2002. From Dr. Parmar’s interpretation of the FCE, he determined that claimant could “work pretty comfortably within her job demands.”⁴ Dr. Parmar concluded that claimant was a candidate for left carpal tunnel release surgery. But Dr. Parmar could not provide an opinion “with all certainty that this [is] all work-related, since she hadn’t been working.”⁵

Claimant’s attorney sent claimant for an independent medical examination to plastic surgeon Dr. Richard J. Bene, M.D. Dr. Bene saw claimant on September 18, 2002. After completing a physical examination of claimant and receiving the EMG and nerve conduction study results from Dr. Katta, Dr. Bene determined claimant required no further medical treatment for her right upper extremity. But he recommended nerve conduction studies for the left upper extremity in order to determine whether surgical intervention was necessary.

After claimant’s tennis elbow release and her carpal tunnel release surgeries, claimant was unable to use her right extremity to perform her daily living activities including her house work. Thus, claimant used her non-dominant left upper extremity to perform those activities. The first time claimant had left upper extremity symptoms was after both of those surgeries when she was required to use her non-dominant left upper extremity instead of her dominant right upper extremity.

In a workers compensation case, every natural and probable consequence that flows from a compensable primary injury, including a new and distinct injury, is compensable if it is a direct and natural result of the primary injury.⁶ In the case of

³ P.H. Trans., Cl. Ex. 1.

⁴ P.H. Trans., Cl. Ex. 1.

⁵ P.H. Trans., Cl., Ex. 1, Dr. Parmar’s Oct. 14, 2002, medical note.

⁶ See *Jackson v. Stevens Well Service*, 208 Kan. 637, 643, 493 P.2d 264 (1972).

Woodward,⁷ the Court of Appeals affirmed the Board's finding that an October 18, 1991, compensable left knee injury had caused injury to claimant's right knee as a result of overcompensating for the injured left knee. The Board concluded that claimant had sustained bilateral knee injuries as the result of his October 18, 1991, work-related accident.⁸

Here, the Board concludes, when the testimony of the claimant is balanced with the medical evidence contained in the preliminary hearing record, the greater weight of the evidence proves that claimant's current left hand symptoms are the natural and probable consequence of her compensable primary right upper extremity injury. Thus, the Board reverses the Assistant Director's Preliminary Decision. The Board appoints Dr. Parmar and Dr. Katta as claimant's authorized treating physicians to evaluate and treat her left upper extremity problems, as they deem reasonable and necessary, including any referrals.

In regard to the Assistant Director's Decision to limit temporary total disability compensation through October 14, 2002, the Board finds, at this juncture of the proceedings, it does not have jurisdiction to review that issue.⁹ Thus, the claimant's appeal in regard to the payment of temporary total disability compensation is dismissed.

WHEREFORE, it is the finding, decision, and order of the Board that Assistant Director's October 28, 2002, Preliminary Decision is reversed in regard to the finding that claimant's left upper extremity problem is not compensable and claimant's appeal in regard to payment of temporary total disability benefits is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

Dated this ____ day of January 2003.

BOARD MEMBER

⁷ *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, 949 P.2d 1149 (1997).

⁸ *Woodward* at 513.

⁹ See K.S.A. 44-534a(a)(2).

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